Ilford Homes Limited

Sweetcroft Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 31 August and 1 September 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day.

The last inspection visit took place on 7 August 2014 at which time we found the standard for supporting staff was not being met because the service was not completing appraisals. An action plan was submitted on 28 August 2014 and we reviewed the evidence the provider sent to us, which included samples of completed appraisals. We carried out a review of the information on 31 December 2014, which confirmed the standard was being met. At the inspection on 1 September 2016, not all the staff had an up to date appraisal.

Sweetcroft Residential Care Home is part of Ilford Homes. It provides personal care to older people and accommodates a maximum of 20 people. At the time of our inspection there were 20 people living at the service.

The registered manager was previously a care worker in the home and became the registered manager in 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found three breaches of the Regulations. People's capacity to make decisions had not been assessed and their consent to care and treatment was not always recorded.

The provider had not always followed procedures for raising incident notifications to the Care Quality Commission.

The service had some systems to monitor the quality of service delivered and ensure the needs of the people who used the service were being met. However, files for staff and people who used the service were missing relevant information. Additionally there was a lack of analysis of information used to improve service delivery.

The service had a safeguarding policy. Staff had attended safeguarding training and knew how to report safeguarding concerns. Risks to people's safety and wellbeing had been assessed to keep people safe and staff knew how to record incidents and accidents. The provider followed safe recruitment procedures.

There were a number of regular maintenance and service checks carried out to ensure the environment was safe. Medicines were administered and stored safely but there was not information on PRN (as required) medicines included in the policy. We recommended that there are robust systems in place to ensure the proper and safe management of medicines at all times.

Team meetings were not held consistently. We recommended that team meetings be held on a regular basis.

We recommended the provider improve the decoration.

People were supported to have enough to eat and drink and were able to have food and drinks when they wanted to.

People had access health care services and the service worked with other community based agencies such as the community matron.

People who used the service told us staff were kind and their dignity and privacy was respected.

Activities were not meaningful for everyone who used the service. We recommended that the provider review activity provision in line with the National Institute for Health and Care Excellence (NICE) guidelines.

An appropriate complaints procedure was available in the service user guide. However, complaints were not always recorded. We recommend the service formally records all future complaints made.

All stakeholders indicated they could speak to the registered manager, who they felt listened to them.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were administered and stored in a safe way but there was not information on PRN (as required) medicines included in the policy.

There were procedures in place to safeguard people from the risk of abuse and staff knew how to respond if they suspected abuse.

Risk assessments minimised harm to people using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not always work within the principles of the Mental Capacity Act (2005) because people's capacity to make decisions had not been assessed and their consent to care and treatment was not always recorded.

Team meetings were not held regularly.

People were supported with food and drink to meet their individual needs.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals such as the community matron.

Is the service caring?

Good

The service was caring.

People who used the service had developed positive relationships with staff.

People's privacy and dignity were respected.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were aware of people's individual needs and they were able to identify the routines and preferences of people living in the service.

Activities were not meaningful for everyone who used the service.

There was a complaints procedure and people said they would speak with the registered manager about concerns they had. However, complaints were not always recorded formally.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not always raise incident notifications as required by the Care Quality Commission.

The service lacked effective systems to monitor the quality of the service delivered to ensure the needs of the people who used the service were being met.

There was a lack of analysis of information to use and improve service delivery.

Maintenance and service checks were carried out to ensure the environment was safe.

People who used the service, relatives and staff said the registered manager was approachable and listened.

Sweetcroft Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 31 August and 1 September 2016. The first day of the inspection was unannounced and we told the registered manager we would be returning the next day.

The inspection team on 31 August 2016 included an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience on this inspection had experience of caring for family members who use regulated services. The inspection on 1 September 2016 was carried out by an inspector only.

Prior to the inspection, the service completed a Provider Information Return (PIR). This form asked the provider to give some key information about the service, what the service did well and improvements they planned to make. Additionally, we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team and Safeguarding Team and there were no concerns raised in the feedback they provided.

During the inspection, we spoke with seven people who used the service and six relatives. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We interviewed nine staff including the

registered manager and we spoke with a visiting healthcare professional.

We looked at the care plans for six people who used the service. We also saw files for seven staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

Requires Improvement

Our findings

People who used the service and their families told us it was safe. People said, "Yes I do (feel safe), at night time everything is locked up and I have never had any reason to worry", "Yes, someone is always around if I need anything", "Yes. I feel very safe knowing someone is here" and a relative said, "Staff have the skills to care for (person) and they're safe."

The service followed safe recruitment procedures to ensure staff were suitable to work with people who used the service. The care workers' files had application forms, two references, Disclosure and Barring Service (DBS) checks, proof of identity and where required proof of permission to work. DBS checks were only undertaken at the initial stage of employment and we saw one as old as 2009. As no subsequent checks were undertaken people were at risk of being supported by unsuitable staff. However, following our inspection, the provider submitted evidence that they had addressed this issue by issuing a disclosure letter instructing staff that they must disclose any conviction for a criminal offence subsequent to their appointment to their role and their initial DBS check.

Care workers we spoke with had attended safeguarding training, were able to identify various types of abuse and told us they would alert the manager to any safeguarding concerns, and if required, alert the local authority and the Care Quality Commission. Care workers also understood how to raise concerns using the whistle blowing policy.

The home had individual risk plans for each person who used the service which included moving and handling and falls. The falls risk plan of care recorded the assessed need, the aim of the care and instructions on how to meet the need. The plans provided staff with guidelines to reduce risk and were reviewed monthly.

Staff knew where to record incidents and accidents, how to complete body charts (to indicate where injuries had occurred) and how to contact emergency services if required. The service had an accident procedure and details of the accident / incident and the subsequent actions were recorded. These were audited monthly by the registered manager but there was no analysis to inform future practice and reduce the likelihood of harm.

The service had a contingency plan dated September 2015 that set out arrangements for emergencies, however not all the sections were completed. The fire risk assessment for the service was dated February 2015. We saw up to date safety checks for fire equipment and weekly fire alarm tests. Emergency equipment

including first aid supplies and fire equipment was situated throughout the service. People who used the service had individual personal emergency evacuation plans (PEEPs), however one person's was missing from the file. There was a fire register but without looking at each individual PEEP, it was not clear what level of support each person required. There was an up to date gas safety certificate and legionella testing carried out. The infection control audit included a weekly health and safety checklist. Checks showed that lifting equipment such as hoists were safe to use. We saw that fridge and freezer temperatures were checked daily.

The environment was clean and a relative observed that, "On the whole, another attribute is the place is reasonably clean."

During our inspection we observed there were enough staff to meet the needs of the people in the service. Comments from people using the service, relatives and care workers included, "Generally they have enough staff. They multi-task (some staff had both care worker roles and domestic roles)", "At the moment it can be a bit short staffed when people are on holiday", "Don't have enough staff. Some days it's fine and others it's hard", "There is enough staff. We manage nicely", "Lots of staff here all times of the day. I think it is ok", "I'm not sure I guess it is alright. Never had any problems" and "They say they are enough but I think they are short." When we asked people if their call bells were answered promptly, they told us "Yes they are really good. Takes them less than five minutes", "I don't use it often but when I press it they are good at answering it" and "Yes sometimes. They are really busy with changeover but they are really good."

The medicines policy indicated every person had the right to keep and administer their own medicines wherever they were able to do so. However, no one in the service was administering their own medicines. The policy also said people were required to give consent to being supported with their medicines but not all people had their capacity to consent assessed or had signed a consent form. The policy included guidance on self-administration, storage and refusal but did not contain information guidelines on PRN (as required) medicines. We saw one person was being given PRN medicines daily and the registered manager said they would request a medicines review with the GP.

We recommend that the provider ensures there are robust systems in place to ensure the proper and safe management of medicines at all times.

During the inspection we looked at medicines administration records (MAR) for four people and the controlled drugs administration for two people. Medicines were dispensed from blister packs and information contained within MAR charts included people's photos and identified allergies. Topical cream applications were recorded on body charts and the MAR charts. Controlled drugs were stored safely and we saw two signatures when these drugs were administered. There were no discrepancies in the recording of medicines administered and the samples of stocks we counted were accurate and could be reconciled with the records of administration. Medicine audits were also being undertaken monthly and this gave us assurance that medicines were being administered safely.

Requires Improvement

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA and had completed three DoLS applications, which were still pending at the time of the inspection, but they had more applications to make. However, most care workers did not have an understanding of the MCA or Deprivation of Liberty Safeguards, (DoLS) and therefore lacked a working understanding of the principles around choice and consent.

We looked at how capacity and consent to care was recorded. The service had a general consent form and two additional consent forms for medicine administration and finance. Four of the six files we looked at did not have signed consent forms. We saw that files had a mental health assessment tick list tool, but it was not clear if people had been assessed as having capacity to consent, and if they did not have capacity, how a best interest decision had been made. Additionally we saw the use of bedrails without consent. Therefore consent to care and treatment was not always sought in line with MCA legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff team was stable and a number of care workers had been with the service for many years. We saw evidence care workers were supported to have the skills and knowledge they required to carry out their role through training, supervisions and observations. One member of staff who had a medical condition had a risk assessment that identified the action required to make reasonable adjustments for them to carry out their duties. The registered manager told us care workers were provided with an induction when they began working for the service but these were not recorded. The training matrix indicated care workers had undertaken training in safeguarding, health and safety, medicines, dementia and the Mental Capacity Act (MCA) 2005. Some care workers told us they had undertaken MCA training and others said they had not but

the registered manager said everyone would be attending Mental Capacity Act 2005 training in November 2016.

Supervision alternated with one to one observation sessions and was completed and recorded every other month. A care worker told us, "I think supervision is useful because anything you don't understand, you can talk through with them (managers) and (talk about) changes and updates. They're always willing to listen." Another care worker told us they received supervision six monthly and had an appraisal six months ago. The files we viewed contained appraisals but some were dated 2014 and therefore they were not all up to date.

Relatives said staff kept them informed. Care workers also felt there was good communication in the service and said, "We all work as a team and help each other out." Staff told us team meetings were held once a year. We saw team meeting minutes from August 2015, which were directive and contained little staff input. The lack of team meetings meant there were less opportunities for staff to be involved in providing feedback and contributing to how the service was run.

We recommend that team meetings are held on a regular basis.

We saw there was a choice of food which most people were satisfied with. People we spoke with said, "Yes they are very good, they come around in the morning with the menu and you get to choose. You get plenty of coffee with snacks and too much in fact as the meals are ample", "Not bad, it's what you expect", "I don't like potatoes every day", "The food is always nice with a few choices" and "The food here is quite nice and we get a lot of it."

Menus were written monthly with lunch and dinner choices. The cook asked people their food likes and dislikes and recorded it in a book kept in the kitchen. We saw that the copies of people's preferences that were held in the kitchen were all dated June 2014 and were not updated to reflect changing tastes or new people in the service The kitchen kept a record of people's dietary needs such as if they were diabetic or required soft food and a list of people's allergies. Care workers asked people each day what they would like for lunch and dinner and wrote it down for the cook. The main meal was at lunch time and care workers provided the evening meal. At lunchtime we observed people had a choice of freshly prepared meals and staff appropriately supported people who required assistance with their meals. Care workers told us, "Dietary needs are in the care plan and we know them." They also said if people wanted to eat during the day, they could access fruit, biscuits or sandwiches from the kitchen.

People who used the service were supported to maintain good health and we saw from the files a number of health professionals, including the dietician, optician, district nurse and GP were involved in providing appropriate health care. The care plans included information about people's nutrition and weight. The nutritional care plans identified risks, strengths, goals and an action. These were reviewed monthly and signed off by staff. We asked people if they saw other health care professionals and they told us, "I have not needed one yet", "I see my own doctor and dentist" and "I can when I need one. I just need to tell one of the girls."

Relatives said the home was effective at monitoring people's health conditions. One relative told us the staff took care of nursing and medical needs, another said their relative had seen the nutritionist, which we verified in the file, and two relatives said psychology had been involved with people's care. Another relative said when (person) was acting out of character, staff thought it might have been because of a urinary tract infection and contacted a medical professional straight away. A healthcare professional we spoke with said the staff had the appropriate skills for a residential care setting and that they had the awareness to signpost to the appropriate agency if needed.

We observed that repairs had been made to the walls in the home, but saw that the paintwork had marks on it. Both relatives and staff repeatedly told us that there was a need for the décor to improve. A relative told us they were concerned about the lack of support from the provider and said they had not seen any investment in the infrastructure or décor. Another relative said the maintenance and decoration could be better and the home "hasn't been freshened".

We recommend the provider improve the decoration.

Good

Our findings

People who used the service indicated that staff were kind, but they did not have a lot of time to sit and talk with people. Comments included, "No they don't (sit and talk with people). Well they do try sometimes", "Yes, I think they do try, but they are normally very busy and don't have time to talk to you", "Sometimes they talk to you, whenever they can", "They are always busy but they will take time out to help you if you need it", "Yeah they do but conversations are very limited. No they don't listen", "We talk sometimes" and "When they have a moment they will talk to me and yes they do listen to anything I say to them; well I hope they do." A relative said their relative was active and there was always "a bit of banter" with the staff.

When we asked people if staff were caring toward them, they said, "Yes they listen to you and act on what you want", "They are very good and caring", "The staff are caring but they are very busy", and "Yes I like them all. They try and help out as much as possible." Relatives said, "I can't praise them enough", "The staff are really marvellous. They can't do enough for (person). No matter what time of day or night, you're welcome", "They (staff) are kind to him. They talk to (person) and they prompt them", "They treat (person) as one of theirs", "They do know (person) as an individual", "I think it's been excellent. Nothing is too much trouble. Nice small home that suits them. (Person) is settled and happy" and "It's good. This environment suits (person). Staff know how to respond to (person). (Person) feels this is home. Because of the care, (person) has exceeded the doctor's expectations." A healthcare professional we spoke with told us the staff showed "care and compassion" and were "empathic and very supportive". They said that there was a good rapport with the majority of people's families and that they received good feedback from the people using the service. A care worker said, "I love my job. It's so rewarding. Some residents don't see a lot of people and it's just nice to be able to care for them." Another care worker told us they read people's care plans but it was good to be able to sit and talk to people to get to know them. However, they also said they did not always have time to sit and talk.

The interaction between care workers and people who used the service was positive. We observed care workers using written signs to communicate with a person who had hearing difficulties and we saw that care workers took their time when they were walking with people and had a good rapport, talking with people as they went. Care workers told us they promoted independence by encouraging people to do as much as they could for themselves. One care worker said, "Always encourage especially with mobility because you don't want them to rely on a wheelchair."

People's privacy and dignity was respected. Staff knocked on doors before entering people's rooms. People

said, "The door is left open but they do say something before they enter" and "I like my door shut. They do knock." A relative observed, "From what I see, I think they (staff) respect them (people who use the service)."

When we asked care workers how they supported people with personal care, they told us, "Try to maintain their dignity and respect. Some (people) do find it hard if you take them into a bathroom. Just reassure them and explain what you are doing and they're fine. I always explain what I'm going to do and ask if they're okay with it." When asked about personal care, people who used the service commented, " They look after you really well", "The door is shut when they are giving me a wash", "I don't really know I guess they look after us the best they can" and " The way they speak to me is nice, like they really care."

Requires Improvement

Our findings

We reviewed people's files to see if individual needs and preferences were met. We saw pre-assessment forms included health, falls history, medicines, mental state, social and medical history. However, the assessments were not always signed. Care plans indicated preferences such as what time people liked to get up and go to bed at, and if they preferred a shower or bath. A care worker said, "People can get up when they choose (in the morning). If they don't want to get up, we'll come back later." Each care plan section had a review form attached to it which was signed monthly to say a review had happened and whether or not changes were required to the care plan. Reviews were consistently undertaken each month but these were completed by the staff without input from the people who used the service.

When we asked if people were involved in their care, people who used the service told us, "I am quite outgoing and I will speak my mind if anything is going wrong", "I don't have any problems that need changing and they know what needs to be done and they do it" and "I can talk about anything that is wrong and they will sort it out." One relative said they and their relative were involved in care planning and they had attended a review six months ago. Another relative said they always discussed their relatives' care but there was not an official review. Care workers told us reviews were undertaken monthly by the key worker and if something needed updating, the plan was given to the registered manager or deputy manager to update.

Staff recorded the care provided to people in daily log sheets. These were mainly task orientated and included, medicines, meals, personal care and comments such as "(Person) has been fine". However, they showed that care plans were being followed. We saw a care plan that was updated to include the person seeing the dietician and saw that it was recorded in the daily logs when the person did see the dietician.

One of the senior care workers was also the activity co-ordinator. They were not aware of the National Institute for Health and Care Excellence (NICE) guidelines around activities but were about to start a vocational course in activities. There was not a specific activities schedule. When the activities co-ordinator was on shift, they did chair exercises and played ball games with people who used the service. They told us they did arts and crafts every other day and other activities included bingo, throwing hoops, talking about the past and reminiscence flash cards.

People who used the service said, "I play bingo, some drawings, play games things like that", "I don't like to take part in any of that", "I enjoy the music they put on", "I like playing games" and "No I don't like to take part. I just like to sit in the garden." During the inspection, we observed people joining in with crafts and a

game of bingo with a care worker who was friendly and tried to engage people in the activity. One relative told us there was a lack of meaningful activities. They said staff encouraged people to join in with what they had but sometimes there was a lack of imagination around the activities. Another relative said the home could provide more activities. They suggested the home needed more background on people so they would know what people might be interested in talking about or doing. A third relative said that residents had been involved in planting flowers and the activities co-ordinator had been "championing" that.

We recommend that the provider review activity provision in line with NICE guidelines.

There was an appropriate complaints procedure which was available in the service user guide. A care worker told us, "There's a complaints form. If families have a complaint we issue them with a form and then it's taken up with the manager." The registered manager said there had been no complaints in the last year, however one relative told us of a complaint they made that they felt had not been dealt with satisfactorily. When we discussed it with the registered manager they said they had put a process in place to prevent a reoccurrence of the incident but this was not formally documented. Relatives were unaware of the complaints procedure but said they would contact the registered manager. One relative told us if they had a concern, they would speak to the registered manager or a senior. "(Registered manager) listens." Another said, "A key attribute is they keep me informed if there are problems."

We recommend the service formally records all future complaints made.

Requires Improvement

Our findings

The service had a recent incident where a person fell and broke a bone. The service dealt with the incident appropriately and sought medical attention for the person, however the incident was not reported to Care Quality Commission as a serious injury notification as required under the Regulations.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service had some systems to monitor the quality of service delivered and we saw checks included infection control audits, maintenance, cleaning checks and monthly medicines audits. However, in other areas such as files for staff and people who used the service, we saw gaps in the required information including consent forms in people's files. We saw the service did not record a complaint from a relative and as a result, complaints could not be monitored effectively. This meant the service was not always able to monitor how the needs of the people using the service were being met. Additionally we did not see any analysis, for example from the feedback of people who used the service and their families, contributing to action plans for service improvements. The lack of documented outcomes for people and what actions were required to improve the service meant there was not a comprehensive view of how the service was run and if it was meeting the needs of the people who used it.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us, "The (registered manager) listens to what you have to say and they act on it", "The (registered manager) is very nice. Can talk to them whenever I want", "I have spoken to (the registered manager) a few times when they are around. They are very good", "I like (the registered manager) I think they are good at their job", The (registered manager) is around to talk to" and "The (registered manager) is very nice, very understanding. I have asked them for many different things and they do help me." Relatives said they could speak to the registered manager and they listened and "(Registered manager) is very good. They will text me and keep me up to date. Never an issue with letting me know what's going on."

The registered manager had a good understanding of the needs of people who used the service. We observed they were active in working alongside staff which provided them with a good overview of how care workers provided support. Care workers we spoke with felt supported by the registered manager and said, "Any problems you have (the registered manager) will always listen and take time out to settle the problem.

They're very approachable. If you need help, they're there" and "I can talk to (registered manager) no problem at all."

The service had been inspected by the local authority's Quality Assurance Team the same week we inspected and a number of issues we raised were also raised by the Quality Assurance Team. The registered manager was open to the feedback and planned to make improvements in the identified areas. For example, the registered manager acknowledged the need to have a better understanding of the Mental Capacity Act (MCA) 2005 in order to effectively comply and had organised MCA training for November 2016.

The last survey for people who used the service was from 2014. When we asked people if they had been asked how they would like the service to run or if they attended resident's meetings, people said they had not been asked nor had they attended residents' meetings. Resident and relatives' meetings were held yearly and the last one was held on 29 May 2015. Relatives told us that they would like the provider to attend these meetings so they could raise specific issues such as the maintenance and décor of the home, directly with them. However, at the time of the inspection, this had not happened.

The service kept up to date with current best practice and legislation through information from the provider and speaking with other healthcare professionals such as the community matron. The service had a good working relationship with various community-based professionals that contributed to them being able to meet people's individual needs. A health professional we spoke with told us the service was very good, "on the ball with any problems" and it is always very welcoming and friendly. They said people were supported in a timely manner and the staff followed through on instructions from health care professionals.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Care Quality Commission of injuries to a service user. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always seek consent for care and treatment from the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not did maintain accurate, complete and contemporaneous records in respect of each service user, persons employed in the carrying on of the regulated activity or the management of the regulated activity.

Regulation 17(2) (c) and (d)